effect a change in behavior, in addition to the other services delivered by physicians and nurses.

(g) Physical therapy, occupational therapy, speech therapy, audiology, respiratory therapy, and psychosocial services or social work services must be provided directly or supervised by professionals who are licensed or certified as appropriate, and the facility must provide supplies required for the provision of these services.

(h) As indicated by the individual program plan, cognitive retraining as defined in paragraph (B)(2) of this rule. The individual program plan must indicate which professionals have responsibility for documentation and evaluation of the cognitive retraining program and their corresponding reinforcement interventions.

(i) As indicated by the individual program plan, neurobehavioral rehabilitation services as defined in paragraph (B)(6) of this rule. The individual program plan must indicate which professionals have responsibility for documentation and evaluation of the neurobehavioral rehabilitation services and their corresponding reinforcement interventions; and

(8) Preliminary evaluation.

The provider must, prior to the individual's admission, develop accurate assessments or reassessments by an interdisciplinary team which address the individual's health, social, psychological, educational, vocational, and chemical dependency needs and submit a copy of this preliminary evaluation to the ODJFS designated outlier coordinator or ODJFS designee; and

(9) Initial assessment.

The provider must develop and submit to the ODJFS designated outlier coordinator or ODJFS designee within fourteen days after admission, accurate assessments or reassessments by an interdisciplinary team which address the individual's health, social, psychological, educational, vocational, and chemical dependency needs, to supplement the preliminary evaluation conducted prior to admission; and

(10) Individual plans.

The provider must develop and submit to the ODJFS designated outlier coordinator or ODJFS designee within fourteen days after admission, a

comprehensive, individualized program plan for coordinated, integrated services developed by the interdisciplinary team, including the ODJFS case manager, in conjunction with the individual and others concerned with the individual's welfare. The plan must state the specific objectives necessary to address the individual's needs as identified by the comprehensive assessment, specific treatment modalities, anticipated time frames for the accomplishment of objectives, measures to be used to assess the effects of services, and person(s) responsible for plan implementation. The plan must include intervention strategies for the twenty-four-hour a day, seven-day a week reinforcement of the cognitive retraining and/or neurobehavioral rehabilitation programs developed for the individual in order to effect a change in behavior. The plan shall be reviewed by the appropriate program staff at least monthly, revised as necessary, and when revisions are made, submitted to the ODJFS designated outlier coordinator or ODJFS designee by facsimile device (FAX) within three working days following the revision; and

(11) Monthly reports.

The provider must prepare and provide to the ODJFS designated outlier coordinator or ODJFS designee a monthly report in a format approved by ODJFS that summarizes the individual's program plan, progress, changes in treatment, and discharge plan, including referrals made and anticipated time frames; and

(12) Discharge plan.

The provider must develop and submit to the ODJFS designated outlier coordinator or ODJFS designee within fourteen days after admission, a written discharge planning evaluation developed by the interdisciplinary team, including the ODJFS case manager, in conjunction with the individual and others concerned with the individual's welfare; including recommendations for any counseling and training of the individual and family members or interested persons to prepare them for post-discharge care, an evaluation of the likely need for appropriate post-discharge services, the availability of those services, the providers of those services, the payment source for each service, and dates on which notification of the individual's needs and anticipated time frames was or would be made to the providers of those services; and

(13) Reassessments of discharge plan.

The provider must, when periodic reassessments of the discharge plan indicate that the individual's discharge needs have changed, submit the results

of the reassessments and the revised discharge plan to the ODJFS designated outlier coordinator or ODJFS designee.; and

(14) Continued stay denials.

The provider must, if prior authorization is denied during an assessment that was requested for an individual who is already residing in the NF-TBI unit, agree to move the individual to the first available NF bed that is not in the TBI unit for as long as NF services are needed, or until such time as a more appropriate placement can be made, and to accept payment for the provision of services at the NF level in accordance with rule 5101:3-3-43 of the Administrative Code; and

(15) Financial records.

The provider must agree to maintain such records necessary to fully distinguish the costs of operating the TBI unit, to disclose the extent of services provided by the TBI unit, and to maintain all information regarding payments claimed by the provider for furnishing NF-TBI services for a period of six years; or if an audit is initiated within the six-year period, until the audit is completed and every exception resolved.

(E) Prior authorization for services.

Reimbursement for NF-TBI services covered by the medical assistance program is available only upon prior authorization from the ODJFS prior authorization committee in accordance with the procedures set forth in this paragraph of this rule. Unless the individual is seeking a change of payor, the prior authorization of payment for NF-TBI services must occur prior to admission to the NF-TBI unit; or, in the case of requests for continued stay no later than the final day of the previously authorized NF-TBI stay.

(1) Initial request.

In order to initiate the application process for the prior authorization of NF-TBI services, the provider of NF-TBI services must submit to the ODJFS designated outlier coordinator or ODJFS designee, a written request for the prior authorization of NF-TBI services. All requests must be in writing and may be submitted by mail or fax. No telephone requests will be honored. The request should be mailed or faxed to "the Bureau of Long Term Care Facilities, 30 East Broad Street, Columbus, Ohio 43215-3414" to the attention of the ODJFS designated outlier coordinator. The request is considered to be "submitted" when it is received by the ODJFS designated outlier coordinator or designee.

(2) Initial application requirements.

It is the responsibility of the provider to ensure that all required information be provided to ODJFS as requested. Prior authorization for NF-TBI services shall not be given until all of the initial application requirements set forth in this rule have been met. An initial application for the prior authorization of NF-TBI services is considered to be complete after:

(a) An JFS 03142 form which requests prior authorization of medical services, has been appropriately completed and submitted; and

(b) An JFS 03697, or an alternative form specified by ODJFS, which accurately reflects the individual's current mental and physical condition and is certified by a physician, has been appropriately completed, a LOC determination has been made as set forth in rule 5101:3-3-15 of the Administrative Code, and a determination regarding the feasibility of community-based care has been made. If the individual is required by rule 5101:3-3-15.1 of the Administrative Code to undergo PAS, the completed JFS 03622 and the results of all required pas determinations must also be attached to the JFS 03697 or approved alternative form.

(c) The JFS 03697, or the ODJFS authorized alternative form, must be completed and contain the information as required by rule 5101:3-3-15 of the Administrative Code, and to the maximum extent possible be based on information from the minimum data set version 2.0 (MDS 2.0).

(d) The JFS 03697, or alternative form authorized by ODJFS, must be sufficiently complete for a LOC determination to be made.

(3) Initial assessment.

The ODJFS determination shall be based on the completed initial application and may include a face-to-face visit by at least one representative of ODJFS with the individual and, if applicable, the individual's representative and, to the extent possible, the individual's formal and informal care givers, to review and discuss the individual's care needs and preferences, and to obtain any additional information or documentation necessary to make the determination of eligibility for NF-TBI services.

(4) Prior authorization determinations.

Based upon a comparison of the individual's condition, service needs, and the requested placement site, with the eligibility criteria set forth in paragraphs (C) and (D) of this rule, the ODJFS outlier prior authorization committee shall conduct a review of the application, assessment report, and supporting documentation about the individual's condition and service needs to determine whether the individual is eligible for NF-TBI services

(5) Notice of determination.

When the prior authorization request has been processed by the outlier prior authorization committee indicating approval, denial, or deferral of the request for authorization of reimbursement, notices shall be sent via mail, that include all of the determinations made and the individual's state hearing rights, in accordance with Chapter 5101:6-2 of the Administrative Code, to the individual, the individual's representative (if any), and the provider. The provider may perform any service(s). However, reimbursement by ODJFS is limited to services approved as indicated in the approval letter.

(a) Denial.

When a request for prior authorization of reimbursement for NF-TBI services is denied, the department will issue a notice of medical determination and a right to a state hearing. A copy of this denial notice will be sent to the CDJFS to be filed in the individual's case record. The notice shall also include an explanation of the reason for the denial.

(b) Approval.

When a request for prior authorization of reimbursement for NF-TBI services has been approved, the department will issue an approval letter which will include an assigned prior authorization number. The notice shall also include the number of days for which the NF-TBI placement is authorized; the date on which payment is authorized to begin; and the name, location, and phone number of the staff member of ODJFS who is assigned to monitor the individual's progress in the facility, participate in the individual's interdisciplinary team, and monitor implementation of the individual's discharge plan. A copy of this approval notice will be sent to the CDJFS to be filed in the individual's case record.

(i) Authorization for initial length of stay.

Individuals who are determined to have met the eligibility criteria set forth in paragraph (C) of this rule may be approved for an

initial stay of up to a maximum of ninety days. The number of days that is prior authorized for each eligible individual shall be based upon the submitted application materials, consultation with the individual's attending physician, and/or any additional consultations or materials required by the ODJFS designated outlier coordinator or ODJFS designee to make a reasonable estimation regarding the individual's probable length of stay in the NF-TBI unit.

(ii) Authorization for continued stays.

Continued stay determinations shall be based on either monthly reports from the facility regarding critical events and the status of the individual's medical condition, or on face-to-face assessments. Continued stay reviews must meet the assessment requirements set forth in this rule. Continued stays may be approved for maximum increments of sixty days.

(6) Discharges

The individual is expected to be discharged to the setting specified in the individual's discharge plan at the end of the prior authorized initial or continued stay, and progress toward that end shall be monitored by the ODJFS designated outlier coordinator or ODJFS designee throughout the individual's NF-TBI unit stay. However, in the event that it is not possible to implement the individual's discharge plan, coverage of NF-TBI services may be extended beyond the previously approved length of stay via the submission to ODJFS of a written request for the continuation of NF-TBI services by the provider. Unless there is a significant change of circumstances within the week preceding the expected discharge date which prevents implementation of the discharge plan, such requests must be submitted at least one week prior to the last day of the previously authorized stay.

(F) Provider agreement addendum.

After ODJFS has approved the NF as a qualified provider of NF-TBI services, both parties shall sign the JFS 03642, an addendum to the Ohio medical assistance program's long term care facility provider agreement (JFS 03623). This addendum must also be signed as a part of each subsequent annual provider agreement renewal with ODJFS, unless the provider chooses to withdraw as a provider of this NF-TBI outlier service or is determined by ODJFS to no longer meet the qualifications set forth in paragraph (D) of this rule.

(G) Authorization of payment.

Authorization of payment to an eligible provider for the provision of NF-TBI services shall correspond with the effective date of the individual's NF-TBI prior authorization approval specified by the ODJFS outlier prior authorization committee, but shall not be earlier than the effective date of the individual's LOC determination. This date shall be:

(1) The date of admission to the NF-TBI unit if it is within thirty days of the physician's signature; or

(2) A date other than that specified in paragraph (G)(1) of this rule. This alternative date may be authorized only upon receipt of a letter which contains a credible explanation for the delay from the originator of the request for the prior authorization of NF-TBI services. If the request is to backdate the LOC and NF-TBI eligibility determination more than thirty days from the physician's signature, the physician must verify the continuing accuracy of the information and need for inpatient care either by adding a statement to that effect on the JFS 03697 or alternative approved form, or by attaching a separate letter of explanation; or

(3) If the individual was required to undergo PAS and failed to do so prior to admission, the effective date of the LOC determination and NF-TBI eligibility determination shall be the later of the date of the PAS determination that the individual required the level of services available in a NF, or the date established in paragraph (G)(2) of this rule.

(H) ~~Initial contracted rate.~~Initial and subsequent contracted rates.

ODJFS will establish the initial contracted rate and contracted rates subsequent to the initial rate year in accordance with rule 5101:3-3-25 of the Administrative Code.

~~(1) The initial rate for a newly approved provider of NF-TBI services will be set in accordance with rule 5101:3-3-53 of the Administrative Code.~~

~~(2) ODJFS will establish the initial contracted rate in accordance with rule 5101:3-3-25 of the Administrative Code no later than ninety days after ODJFS receives all the required information. The initial contracted rate will be implemented retroactively to the initial date services were provided pursuant to the NF-TBI provider agreement.~~

~~(a) The following information may be submitted as soon as the provider receives notification from ODJFS of the effective date of the NF-TBI provider agreement, but must be submitted within ninety days of the provider agreement's effective date.~~

~~(i) The projected cost report budget for the initial year of operation; and~~

~~(ii) The current calendar year capital expenditure plan, including a detailed asset listing; and~~

~~(iii) The current calendar year plan for basic staffing patterns, using a format to be approved by ODJFS, that includes the staff schedule by shift, number of staff in each position, staff position descriptions, base wage rates, and a brief explanation of contingencies that may require adjustments to these basic staffing patterns.~~

~~(b) The following information must be submitted no later than ninety days after the end of the actual initial three months of operation as an NF-TBI:~~

~~(i) A cost report for the period of the actual initial three months of service; and~~

~~(ii) Current individual plans (IPs) for residents to be served in the period for which a rate is being established.~~

~~(I) Contracted rates subsequent to the initial rate year.~~

~~(1) The contracted rate will be effective for the fiscal year beginning on the first of July and ending on the thirtieth day of June of the following calendar year.~~

~~(2) ODJFS will establish the contracted rate in accordance with rule 5101:3-3-25 of the Administrative Code no later than the thirty-first day of July of the fiscal year for which the rate will be paid, unless the provider fails to submit all required information by the thirty-first of March. If the provider fails to submit the required information, ODJFS will assign to the outlier facility the simple average rate paid for services delivered during the month of July to NFs based on bed size ranges as defined in rule 5101:3-3-48 of the Administrative Code, and establish the contracted rate no later than ninety days after all information is submitted, but no earlier than the first day of August. The contracted rate will be implemented retroactively to the beginning of the fiscal year.~~

~~(3) The following information must be submitted by the provider in order to establish the contracted rate for any year subsequent to the year of the initial contracted rate:~~

~~(a) Case mix data.~~

~~"MDS 2.0 resident assessment" must be completed and submitted for~~

~~each resident of the NF-TBI in accordance with the requirements and deadlines set forth in rule 5101:3-3-41 of the Administrative Code; and~~

~~(b) Individual plans.~~

~~Current IPs for residents to be served in the period for which a rate is being established by the thirty-first of March of the current calendar year; and~~

~~(c) Cost report and budget information.~~

~~The actual year-end cost report shall be submitted within the deadline specified in accordance with rule 5101:3-3-20 of the Administrative Code. The current calendar year cost report budget shall be submitted by the thirty-first of March of the current calendar year, in conjunction with the previous calendar year's actual cost report; and~~

~~(d) Financial statement information.~~

~~(i) For-profit providers shall submit a balance sheet, income statement, and statement of cash flows for the NF-TBI no later than the thirty-first of March of the following calendar year relating to the previous calendar year's actual cost report submitted in accordance with paragraph (I)(3)(e) of this rule; or~~

~~(ii) Not-for-profit providers shall submit a statement of financial position, statement of activities, and statement of cash flows for the NF-TBI no later than the thirty-first of March of the following calendar year relating to the previous calendar year's actual cost report submitted in accordance with paragraph (I)(3)(e) of this rule; and~~

~~(e) Capital expenditure plan.~~

~~The current calendar year capital expenditure plan, including the detailed asset listing, shall be filed by the thirty-first of March of the current calendar year; and~~

~~(f) Staffing pattern plan.~~

~~The current calendar year plan for basic staffing patterns, using a format to be approved by ODJFS, that includes the staff schedule by shift, number of staff in each position, staff position descriptions, base wage rates, and a brief explanation of contingencies that may require adjustments to these basic staffing patterns shall be filed by the thirty-first of March of the current calendar year; and~~

~~(g) Board minutes.~~

~~Approved board minutes from the legal entity holding the provider agreement and all other related legal entities for the calendar year covered by the actual cost report shall be filed by the thirty-first of March of the following calendar year.~~